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The Honorable Chester A. McPherson
Interim Insurance Commissioner
Department of Insurance, Securities, and Banking
810 First Street, N.E., Suite 710
Washington, DC 20002

Dear Interim Commissioner McPherson:

Enclosed with this letter, you will find the prehearing brief and other filings submitted by Group Hospitalization and Medical Services, Inc. ("GHMSI") in advance of the April 29 hearing on GHMSI's 2011 surplus. Also included is GHMSI's response to the final report by Rector and Associates regarding GHMSI's 2011 surplus ("the Rector Report"). While GHMSI does not agree with every assumption or observation by Rector, the Rector Report holds that GHMSI's current surplus level is appropriate and consistent with GHMSI's obligations under the Medical Insurance Empowerment Amendment Act of 2008 ("MIEAA").

In light of the significant market changes wrought by the Affordable Care Act, we have great concern that GHMSI's current surplus - which is below both Rector's target surplus and the lower limit of GHMSI's target surplus range - will be difficult to maintain in the future.

The Rector Report Validates GHMSI's Surplus Level for the 9th Time. GHMSI maintains its own, well-established process for determining the appropriate level of surplus. Since 2005, GHMSI initiated five full-scale studies by independent actuaries Milliman, Inc. ("Milliman") and The Lewin Group ("Lewin"), along with supplemental updates in 2012 and 2013. GHMSI's Board of Trustees used these studies to set a surplus target and range each year. In addition to these reviews, independent studies by the DISB and the Maryland Insurance Administration (MIA) have approved the surplus ranges set by the GHMSI Board.[1] All of these reviews have been remarkably consistent - each study commissioned by GHMSI, DISB, or MIA has upheld the appropriateness of the Company's surplus position at the time of the review.

The Rector Report does not change GHMSI's view that the surplus range established by its Board is appropriate. Rector's recommended target surplus of 958% RBC-ACL and range of 875% to 1040% RBC-ACL are close to (and overlap with) the range adopted by the GHMSI Board (and higher than the 850% RBC-ACL target that the Commissioner previously approved for the year 2008). GHMSI's 2011 surplus was 998% RBC-ACL, well within Rector's proposed range, and its 2013 surplus of 932% RBC-ACL is well below the midpoint of Rector's range.

[1] In 2009 the MIA retained The Invotex Group and in 2011 the MIA retained RSM McGladrey, Inc., each of whom recommended surplus ranges consistent with those set by the Board. These conclusions were upheld in MIA Consent Orders dated May 26, 2011 and September 14, 2012.

GHMSI Agrees That A Range of Appropriate Surplus Levels Is Required. Rector concludes that, so long as GHMSI's surplus falls within a range determined by actuarial analysis of GHMSI's needs in order to remain financially sound and efficient, GHMSI's surplus is neither unreasonably large nor inconsistent with GHMSI's community reinvestment obligations, and both prongs of the MIEAA are therefore satisfied. Under GHMSI's own policy, its Board sets an appropriate target surplus and range, and GHMSI manages surplus towards the midpoint of that range. GHMSI applied this policy in 2011 and 2012 by lowering rates and reducing rate increases, and its surplus has fallen by 166 points, from 1,098% RBC-ACL at the end of 2010 to 932% RBC-ACL in 2013.[2]

Use of a target and range is necessary because surplus levels are not predictable or achievable with exactitude, as Rector notes on page 12 of the Report. Whether GHMSI's surplus grows or shrinks in a given year depends upon whether the rates approved by regulators are adequate to cover GHMSI's costs in providing coverage, whether medical and administrative costs are as expected, and a host of other factors. GHMSI seeks to manage surplus toward a target, but these uncontrollable or unpredictable factors make achieving a specific target number unlikely in any given year – hence, establishing a target range is the most appropriate way of dealing with this uncertainty.

MIEAA Requires DISB To Coordinate With Maryland. The surplus ranges proposed in the Rector Report conflict with those approved in Maryland. Under the MIEAA, DISB's review of GHMSI surplus must be "undertaken in coordination with the other jurisdictions in which the corporation conducts business." D.C. Code § 31-3506(e). In 2012, the MIA approved a surplus range for GHMSI of 1,000% to 1,300% RBC-ACL. *See* MIA Order No. 2012-09-006 (Sept. 14, 2012). Under the MIA Order, GHMSI must "strive to maintain an actual surplus position . . . at the midpoint of the surplus range[] approved by the Commissioner." *Id.* ¶ G, at 8. This midpoint is 1150% RBC-ACL, nearly 200 points higher than Rector's proposed target. We believe that the DISB should coordinate with Maryland before adopting a specific surplus range for GHMSI to ensure that the company is not subject to conflicting obligations.

GHMSI Cannot Manage Its Surplus Unless It Receives Adequate Rates In The Future. The Rector Report does not fully address the greatest threat to GHMSI's ability to maintain adequate surplus in the future: premium rate adequacy. If GHMSI cannot maintain premium rates that are adequate to cover its expenses, GHMSI's surplus will fall well below the levels recommended by Rector and will not recover.

These are not merely theoretical concerns – GHMSI incurred more than $23 million in losses in the individual markets in DC, Maryland, and Virginia in 2013, including losses attributed to GHMSI from its ownership interest in CareFirst BlueChoice, Inc.

In fulfillment of its non-profit mission and to ease its members' transition to the higher-cost guaranteed issue policies required by the ACA, GHMSI set its 2014 rates below the levels that independent actuarial experts otherwise said would be required to cover medical costs. GHMSI did so in order to provide the greatest possible value to its subscribers as well as to provide them with the benefit of the doubt about ACA risk pool composition. Such rate moderation is, by

[2] From 2010 through 2012, GHMSI contributed approximately $27 million in community reinvestment through moderation of rates within the District of Columbia (in addition to GHMSI's other community reinvestment in DC).

definition, "community health reinvestment" under the MIEAA. *See* DC Code § 31-3501(1A). GHMSI sought an average DC rate increase of 35% for individual and small group market coverage, when independently developed actuarial models suggested that an average increase of 60% or more could be needed to break even in 2014.[3] GHMSI similarly moderated its Maryland rates.

If 2014 rates turn out to be inadequate, it will be difficult for GHMSI to "make up" losses to surplus in future years. Premium rate increases will be required in 2015, 2016 and 2017 because 2014 rates benefit from ACA risk mitigation programs that will be phased out over time. The federal reinsurance program provides carriers with payments to reduce care costs for the sickest individuals, while the federal "risk corridors" program allows carriers to share losses in the new health insurance exchanges with the federal government. While both programs are designed to reduce prices for the consumer, they will be phased out from 2014 through 2016 (2017 is the first year in which neither program would operate).

Other factors also exacerbate the premium rate adequacy problem, such as the decision in the District of Columbia to merge the individual and small group risk pools. This has imposed further uncertainty and could lead to further increases in small group rates.

If GHMSI's 2014 rates are inadequate, increases required to "catch up" and achieve rate adequacy in 2015 and 2016 will have to be added to increases related to the phase-out of ACA risk mitigation programs and increases based on medical cost trends and risk pool composition. Given the political and regulatory pressure to hold rates down, there is substantial risk that GHMSI rates will not keep up with the costs of providing coverage in coming years and that surplus will be significantly reduced as a result.

ACA Risks Will Almost Certainly Drive GHMSI's Surplus Down. GHMSI also believes that Rector has underestimated the ACA's significant market changes, which will drive surplus down on an RBC basis and hinder GHMSI's ability to rebuild surplus once lost.

Increased Enrollment Will Reduce RBC-ACL Levels. For most individual and small group products, GHMSI's filed 2014 premium rates are lower than those of others in the marketplace – particularly on the lower (bronze and silver) tiers most attractive to new market entrants. The likely result will be an increase in GHMSI enrollment and revenue. This is already materializing. A larger surplus will be required (in dollar terms) to maintain a stable RBC-ACL level, because larger enrollment causes larger potential medical claim costs and larger financial risk.

Medical Loss Ratio ("MLR") Rules Prevent "Recapturing" Lost Surplus. GHMSI must pay rebates if its non-medical costs exceed 15% in the large group or 20% in the small group and individual markets. GHMSI, therefore, can only build surplus from the 15 to 20 percent allocated for non-medical costs, from which GHMSI also must pay for employee salaries, broker commissions, equipment, administration, and other such expenses. GHMSI cannot simply

[3] The American Society of Actuaries predicted that 2014 medical claims costs in the individual market are likely to increase by an average of 51.9% for the District of Columbia (the 9th highest increase) and 66.6% for Maryland (the 4th highest increase).

increase rates to rebuild surplus that was lost in a previous year, because rates cannot significantly exceed medical claims costs.[4]

The ACA Will Continue To Impose Massive Additional Expenses On GHMSI. CareFirst and GHMSI spent well in excess of $100 million dollars in 2013 alone on costs associated with implementation of the Affordable Care Act. These ongoing implementation costs will continue for many years with known substantial additional expenses coming. Difficulties in initial operation of the health exchanges have exacerbated this problem, because the unreadiness of the exchanges has forced the company to implement *ad hoc* solutions to problems such as implementation and administration of premium tax credits and cost sharing reductions, temporary enrollments and re-enrollments of members, shifting payment deadlines, and other matters, each of which generates additional expense and risk for GHMSI.

All of the above dynamics contribute to an environment in which it is more likely than ever before that GHMSI will be unable (a) to fully recoup its costs through adequate rates; (b) to increase rates to an adequate levels; (c) to maintain GHMSI's RBC level, which is likely to drop on account of increased enrollment and increased expenses; and (d) to rebuild surplus once lost.

While the Rector Report properly concludes that GHMSI's surplus is neither unreasonably large nor inconsistent with GHMSI's community reinvestment obligations, we believe that Rector underestimates these risks while the current surplus range approved by the GHMSI Board more adequately recognizes them.

In sum, GHMSI is significantly concerned with its ability to maintain adequate surplus, and looks forward to working with DISB and its other regulators to ensure that the Company will continue to meet its obligations to its policyholders while trying to maintain reasonably affordable coverage in a sweepingly charged environment.

Sincerely,

Chet Burrell
President and CEO

[4] This is particularly true because MLR rebates must be separately calculated and paid for every carrier, market segment and jurisdiction – requiring 18 separate calculations for GHMSI and BlueChoice (which is 50% owned by GHMSI), for the individual, small group, and large group markets in DC, Maryland, and Virginia. GHMSI may have underwriting losses in one market segment, while being required to pay rebates in a different segment. On average, therefore, GHMSI will have less than 15 to 20% for administrative expenses or to build surplus.